

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003350	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/15/2015
NAME OF PROVIDER OR SUPPLIER ST VINCENT SETON SPECIALTY HOSPITAL, INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State complaint.</p> <p>Complaint Number: IN00165094</p> <p>Substantiated: No deficiencies related to the allegations are cited.</p> <p>Date 12-15-15</p> <p>St Vincent Seton Specialty Hospital, Indianapolis is in compliance with 410 IAC 15-1.5-1, Dietetic services and 410 IAC 15-1.5-6 Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 02/01/16</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE